



Complete Summary

GUIDELINE TITLE

Cervical cancer screening.

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Cervical cancer screening. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Aug. 29 p. [56 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Cervical cancer

GUIDELINE CATEGORY

Counseling
Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To increase the percentage of women who are up-to-date for cervical cancer screening
- To improve the effectiveness of patient education by taking advantage of regular opportunities to inform women of the need for cervical Papanicolaou (Pap) smear screening

TARGET POPULATION

Adult women age 21 or older or with the onset of sexual activity

Note: Women with complaints secondary to the gynecological system lie outside the scope of this guideline.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Education and counseling about cervical cancer screening
2. Papanicolaou (Pap) smears (traditional and Liquid Based Cytology)
3. Patient notification and follow-up

MAJOR OUTCOMES CONSIDERED

- Effect of prescreening educational and counseling activities on percentage of women presenting for cervical Papanicolaou (Pap) smear screening
- Predictive value of Pap smears
- Benefits of Pap smear procedures, techniques, and various screening intervals
- Incidence of cervical cancer at screening intervals of one, two, and three years
- Impact of screening intervals on incidence of morbidity or mortality from cervical dysplasia
- Mortality due to cervical cancer
- Disadvantages and adverse effects of Pap smear screening

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

No additional description of literature search strategies is available.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Key conclusions (as determined by the work group) are supported by a conclusion grading worksheet that summarizes the important studies pertaining to the conclusion. Individual studies are classed according to the system presented below, and are designated as positive, negative, or neutral to reflect the study quality.

Conclusion Grades:

Grade I: The evidence consists of results from studies of strong design for answering the question addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of any significant doubts about generalizability, bias, and flaws in research design. Studies with negative results have sufficiently large samples to have adequate statistical power.

Grade II: The evidence consists of results from studies of strong design for answering the question addressed, but there is some uncertainty attached to the conclusion because of inconsistencies among the results from the studies or because of minor doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from weaker designs for the question addressed, but the results have been confirmed in separate studies and are consistent with minor exceptions at most.

Grade III: The evidence consists of results from studies of strong design for answering the question addressed, but there is substantial uncertainty attached to the conclusion because of inconsistencies among the results of different studies or because of serious doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from a limited number of studies of weak design for answering the question addressed.

Grade Not Assignable: There is no evidence available that directly supports or refutes the conclusion.

Study Quality Designations:

The quality of the primary research reports and systematic reviews are designated in the following ways on the conclusion grading worksheets:

Positive: indicates that the report or review has clearly addressed issues of inclusion/exclusion, bias, generalizability, and data collection and analysis.

Negative: indicates that these issues (inclusion/exclusion, bias, generalizability, and data collection and analysis) have not been adequately addressed.

Neutral: indicates that the report or review is neither exceptionally strong nor exceptionally weak.

Not Applicable: indicates that the report is not a primary reference or a systematic review and therefore the quality has not been assessed.

Classes of Research Reports:

A. Primary Reports of New Data Collection:

Class A:

- Randomized, controlled trial

Class B:

- Cohort study

Class C:

- Nonrandomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

Class D:

- Cross-sectional study
- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports

Class M:

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R:

- Consensus statement
- Consensus report
- Narrative review

Class X:

- Medical opinion

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developer reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Institute Partners: System-Wide Review

The guideline draft, discussion, and measurement specification documents undergo thorough review. Written comments are solicited from clinical, measurement, and management experts from within the member medical groups during an eight-week period of "Critical Review."

Each of the Institute's participating medical groups determines its own process for distributing the guideline and obtaining feedback. Clinicians are asked to suggest modifications based on their understanding of the clinical literature coupled with their clinical expertise. Representatives from all departments involved in implementation and measurement review the guideline to determine its operational impact. Measurement specifications for selected measures are developed by the Institute for Clinical Systems Improvement (ICSI) in collaboration with participating medical groups following general implementation of the guideline. The specifications suggest approaches to operationalizing the measure.

Guideline Work Group: Second Draft

Following the completion of the "Critical Review" period, the guideline work group meets 1 to 2 times to review the input received. The original guideline is revised as necessary, and a written response is prepared to address each of the suggestions received from medical groups. Two members of the Preventive Services Steering Committee carefully review the Critical Review input, the work group responses, and the revised draft of the guideline. They report to the entire committee their assessment of two questions: (1) Have the concerns of the medical groups been adequately addressed? (2) Are the medical groups willing and able to implement the guideline? The committee then either approves the guideline for pilot testing as submitted or negotiates changes with the work group representative present at the meeting.

Pilot Test

Medical groups introduce the guideline at pilot sites, providing training to the clinical staff and incorporating it into the organization's scheduling, computer, and other practice systems. Evaluation and assessment occur throughout the pilot test phase, which usually lasts for three months. Comments and suggestions are solicited in the same manner as used during the "Critical Review" phase.

The guideline work group meets to review the pilot sites' experiences and makes the necessary revisions to the guideline, and the Preventive Services Steering Committee reviews the revised guideline and approves it for implementation.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The recommendations for the cervical cancer screening are presented in the form of an algorithm with a total of 23 components, accompanied by detailed annotations. An algorithm is provided for: [Cervical Cancer Screening](#). Clinical Highlights and selected annotations (numbered to correspond with the algorithm) follow.

Class of evidence (A-D, M, R, X) and conclusion grade (I-III, Not Assignable) definitions are repeated at the end of the Major Recommendations field.

Clinical Highlights

1. Screening need not be performed for women who have had a hysterectomy for benign disease, provided they have no history of cervical intraepithelial neoplasia (CIN) 2 or CIN 3. (Annotations #4 and 5 - refer to the original guideline document, annotations #7 and 8)
2. Women with a history of CIN 2/3 prior to but not as the indication for hysterectomy should be screened until three consecutive, technically satisfactory normal/negative vaginal cytology tests with no abnormal/positive cytology test within a ten-year period are achieved. (Annotation #7)

3. Initially all women should have annual Papanicolaou (Pap) smear screening beginning at age 21 or within three years of the onset of sexual activity. (Annotation #10)
4. It is appropriate to resume Pap smear screening in a woman age 65 and older who has a new sexual partner. (Annotation #13)
5. After three consecutive normal Pap smears, and no dysplasia within the last five years, women may have their screening performed less frequently at the discretion of the clinician and patient. (Annotation # 14)
6. Screening for cervical cancer should be performed at least every three years. (Annotation #14)

Cervical Cancer Screening Algorithm Annotations

1. Prescreening Educational and Counseling Activities

Employer, School and Community Education Activities

This group, through this guideline, acknowledges the crucial role played by education and outreach efforts in helping to increase the number of age-appropriate women who present themselves for regular cervical Pap smear screening, thereby reducing the incidence of cervical cancer mortality.

The following are some ideas for employers, school, and community organizations.

Awareness initiative programming includes:

- Posters for company bulletin boards
- Payroll stuffers with general screening information
- General screening information "tents" for tables in reception areas, cafeterias, employee lounges, restrooms, locker rooms, and other such places

Educational initiative programming includes:

- Articles in employee newsletters, magazines, and/or newspapers
- Brown-bag lunch seminars, health fairs
- Direct-mail campaigns with screening information sent to all eligible employees and health plan enrollees

Behavioral change initiative programming includes:

- Financial incentive plans, such as employer group programs, which reward enrollees who practice a range of preventive health behaviors including regular cervical Pap smear screening
- Removal of any time, transportation, or other pragmatic barriers to screening
- Making a high-level management commitment to cervical cancer screening and other prevention programs

Information on the importance of regular cervical Pap smear screening can be included as part of broader health promotion/disease prevention initiatives, that include not only cancer prevention education but also address heart disease and appropriate health care utilization as well. Some employers and health maintenance organizations around the country have also launched successful Women's Health Campaigns, which include cervical cancer screening along with other prominent health issues for women, such as breast cancer detection, smoking, exercise, and so on.

Provider Activities Prescreening Educational and Counseling Activities

Materials such as brochures, posters, "special message" prescription pads, chart reminders, and so on can help support the provider in her/his role as patient counselor/educator. Face-to-face opportunities to encourage women - especially those who haven't had a Pap smear recently or ever - to take advantage of this important and potentially lifesaving procedure are instrumental in improving screening rates, thereby reducing cervical cancer mortality.

Suggested health care provider prescreening activities include:

- Use brochures, posters, and direct-mail materials to recruit women for Pap smear screening.
- Have a process in place to communicate results to patients following Pap smear screening, such as:
 - letter/postcard re: need for repeat Pap smear
 - letter/postcard re: normal Pap smear
 - letter/postcard re: Pap smear findings necessitate repeat Pap smear in six months
 - letter/postcard re: Pap smear findings necessitate further diagnostic follow-up
- Have available materials such as brochures, booklets, or videos regarding findings, disorders, and follow-up diagnostic procedures.
- Have a process in place to remind patients regarding their next appointment for Pap smear screening, including any specific patient instructions.
- Have a process in place to identify women who have not had a Pap smear during the past three years and contact them to encourage them to have a screening. (For patients who have not had a Pap smear in the past three years, simply sending out a letter of invitation to have a Pap smear has not been found to be effective. Other techniques, such as follow-up phone calls or opportunistic screening by providers may be more effective.)
- Have available support and awareness-building opportunities for providers to assist them in the role of patient "recruiter" (e.g., chart reminders, special prescription pads, continuing medical education gatherings).

Evidence supporting this recommendation is of classes: A, C, D, M, R

2. Does Patient Have Human Immunodeficiency Virus (HIV)?

As advocated in the 1999 U.S. Public Health Services/ Infectious Diseases Society of America (USPHS/IDSA) guideline for prevention of opportunistic infection in HIV persons, annual screening is recommended after two normal Pap smears six months apart after the initial diagnosis of HIV.

Evidence supporting this recommendation is of classes: M, R

5. Was Carcinoma in Situ (CIS) of Cervical Carcinoma Present at the Time of Hysterectomy?

Women who have had a hysterectomy for carcinoma in situ or invasive cancer should be monitored clinically on at least an annual basis with pelvic exam and Pap smear from the vaginal apex. Immediately following hysterectomy for these indications, a Pap smear should be performed on a more frequent basis.

7. Any History of CIN 2/3?

Women with a history of CIN 2/3 prior to but not as the indication for hysterectomy should be screened until three documented consecutive, technically satisfactory normal/negative vaginal cytology tests with no abnormal/positive cytology test within a ten-year period are achieved.

8. Pap Smear Not Required

Further cytologic examination is not required for women who have undergone a hysterectomy with removal of cervix for benign disease.

Evidence supporting this recommendation is of class: R

9. Perform Vaginal Cytologic Examinations

Perform vaginal cytologic examinations until three documented, technically satisfactory normal/negative tests are obtained within a ten-year period.

10. Initiation of Screening: Within 3 Years of Onset of Sexual Activity or Age ≥ 21 ?

Cervical Pap smear screening should be initiated on all women beginning at age 21 or within 3 years of the onset of sexual activity. In the asymptomatic patient there is no known benefit to performing a pelvic exam as a screening procedure for gynecological disease.

Evidence supporting this recommendation is of classes: R, D

12. Cessation of Screening: Patient ≥ 65 and Has Had 3 Consecutive Normal Paps in the Last 10 Years?

In women who have had previous adequate screening there is no clear evidence on the need for Pap smears in women over 65 years of age. However, there is still a significant incidence in cervical cancer in this age

group in women who have not had previous screening. Pap smears may be performed with mutual consent of patient and provider and should not be performed within less than 2- to 3-year intervals because of the risk of false positives. Please note as well, women who were exposed to diethylstilbestrol (DES) in utero and women who are immunosuppressed should continue Pap smear screening as long as they are in good health.

Women over 65 years of age with a minimum of 3 consecutive normal Pap smears in the past 10 years and who are not otherwise at high risk for cervical cancer may cease routine screening. [Conclusion Grade II: See Conclusion Grading Worksheet - Appendix A – Annotation #12 (Cessation of Screening) in the original guideline document]

Evidence supporting this recommendation is of classes: B, D, R

13. Has Patient Had a New Sexual Partner?

It is appropriate to resume Pap smear screening in a woman age 65 or older who has a new sexual partner.

14. Determine if Previous Adequate Screening has Taken Place Within the Last 5 Years

Adequate screening is defined as within the last 5 years the patient has had:

- 3 consecutive normal, technically satisfactory Pap smears, AND
- no Pap smears indicating possible dysplasia

Although the standard is three annual normal, technically satisfactory Pap smears, a wider time frame is acceptable as long as there are no intervening abnormal Pap smear results. This interval time frame should be three normal Pap smears in a period not to exceed five years.

Patients with a history of dysplasia should have annual Pap smears until they no longer have a history of dysplasia within the last five years. After that time has passed, the patient need not have Pap smears repeated more frequently than the standard recommendation.

After the three consecutive normal Pap smears in five years or less, women may have their screening performed less frequently. Screening for cervical cancer should be performed at a minimum of every three years. A discussion between patient and clinician to discuss the time involved in screening intervals is recommended. Pap smear screening need not be performed for women who have had a total hysterectomy for benign disease, provided they have no history of CIN 2/3 (see Annotations #7 and #8).

15. Does Cervix Appear Normal?

A normal looking cervix is defined in any standard medical text. The presence of eversion and/or Nabothian cysts does not constitute an abnormality in this

context. If a lesion is grossly visible, Pap smear alone does not constitute adequate evaluation; biopsy with or without colposcopy should be done.

16. Out of Guideline/Conduct Further Evaluation and Treatment

Women requiring further evaluation and treatment as a result of their evaluation fall outside the purview of this guideline.

Brochures, booklets, teaching displays, and videos are helpful educational tools for those women who need to undergo any follow-up or diagnostic procedures such as colposcopy, loop electrosurgical excision procedure (LEEP), and the like.

17. Obtain Pap Smear

To enhance the likelihood of obtaining cells from the squamocolumnar junction, the following procedure is recommended:

- It would be best if the patient could be instructed not to use a vaginal douche or any type of lubricant for 24 hours before having a Pap smear obtained. However, this should not preclude a patient from receiving a Pap smear.
- Cytological specimens should be obtained with a non-lubricated speculum before a bimanual pelvic examination, if the latter is performed.
- The cervix and that area of the vagina adjacent to the cervix must be fully visible when the smear is obtained.

A. For Traditional Pap Smears

- The endocervix and ectocervix should be sampled separately (spatula first, cytobrush last).
- A plastic Ayre spatula, preferably with an extended tip, or a wooden spatula is rotated with pressure over the entire ectocervix.
- The standard method for sampling the endocervix is with an endocervical brush, which enhances cell recovery. Proper instructions for use of an endocervical brush include:
 - Sample ectocervical region first using ectocervical spatula.
 - Insert brush into the endocervical canal and rotate one half to two full turns.
 - Transfer collected cells by gently rolling and twisting brush against microscope slide, then apply cytology fixative.

Other devices such as the pointed Ayre spatula also sample the transformation zone. This device is gently inserted into the endocervix and rotated slowly one to two full turns.

- The material is rapidly applied to a glass slide with a frosted end and spread evenly. The material on the slide must be

spread thinly so that microscopic interpretation is possible. Each sample may be placed on a separate glass slide, or alternatively, placed on a single slide.

- The slide is fixed immediately to prevent drying, either by immersing it in a jar of 95% ethyl alcohol and fixing for 15 minutes, spraying with aerosol or pump fixative while holding the spray can at least 10 to 12 inches from the slide, or flooding with the liquid fixative. Slides fixed in 95% ethyl alcohol can be transported to the laboratory in the alcohol bath or allowed to air dry following fixation. Smears fixed with aerosol or flooding must be air dried before sending to the laboratory.

B. For Liquid Based Cytology (LBC)

- A non-wooden spatula may be used or use other instrument provided.
- The cytobrush should not be rotated more than 180 degrees, and only in one direction.
- These collecting devices are then swished along the inner surface of the fluid container at least 20 times around.

Note: Pap smears should not be performed too soon after delivery. The recommended interval should be no sooner than 8 weeks postpartum.

Evidence supporting this recommendation is of classes: C, M, R

19. Repeat Pap Smear

The 2001 Bethesda system of nomenclature for Pap smear interpretation (see Annotation #22, "Evaluate Patient Education Needs and Discuss Patient Risk factors/Respond to Patient Questions and Concerns/Notify Patients of Results and Follow-Up Recommendations") includes an evaluative component describing the adequacy of the specimen. This component is further subdivided into two categories:

- satisfactory for evaluation
- unsatisfactory for evaluation

Because this guideline recommends that Pap smear screening may be performed on an every one-to-three-year basis, this work group is also recommending that any Pap smear reported as unsatisfactory for evaluation should be repeated no sooner than eight weeks after the initial pap but before twelve months.

If reasonable effort to obtain a Pap smear specimen results in continued "absence of endocervical" cells, the Pap smear should be considered normal and need not be repeated more frequently than the standard recommendation. In those patients who are postmenopausal and whose Pap smears are limited by the "absence of endocervical cells," such Pap smears need not be repeated more frequently than the standard recommendation.

Evidence supporting this recommendation is of class: R

21. Is Pap Smear Negative (No Intraepithelial Neoplasia)?

In order to achieve a more consistent manner of cervical Pap smear reporting, it is highly recommended that all providers and their affiliated laboratories adopt the 2001 Bethesda system of nomenclature for Pap smear interpretation as their system of reporting Pap smear results.

Women should be notified of Pap smear results in a manner that is mutually agreeable to the provider and patient. The authoring work group strongly recommends contacting all patients with the results of their Pap smears, whether normal or abnormal. In certain circumstances, state/regional laws may regulate the manner by which a patient is contacted with results of laboratory testing. Contact your state/regional health department for more information.

At the time of results notification, a natural opportunity exists for counseling and education specific to the patient's needs. Women whose Pap smear results are abnormal should receive additional information about their results, including the need for follow-up via a repeat Pap smear or other diagnostic procedure. Written educational materials could also be offered at this time. Every opportunity should be taken to stress the importance of continued regular, periodic cervical Pap smear screening with all women eligible for screening. An opportune time to reinforce this message with women exists during results notification.

Evidence supporting this recommendation is of class: R

22. Evaluate Patient Education Needs and Discuss Patient Risk Factors/Respond to Patient Questions and Concerns/Notify Patient of Results and Follow-up Recommendations

Women who have many risk factors have a greater need to be screened, but do not need to be screened more frequently as long as their prior Pap smears have been normal. Below is a table of risk factors.

The HIV-positive female has a much higher risk of developing cervical cancer and therefore should be screened annually.

Risk Factors

Relative Risks (Case Control Studies) for Cervical Cancer by Specific Risk Factor:

RR = relative risk

- HIV: RR = very high
- Moderate Dysplasia on Pap smear within past five years: RR = very high
- Intercourse within 1 year of menarche: RR = 26

- Intercourse under age 16 years: RR = 16
- No Prior Screening: RR = 10
- Human papilloma virus (HPV) (depending on subtyping): RR = 2.5 - 30
- Six or more lifetime sexual partners: RR = 5
- Low socioeconomic class: RR = 5
- Race (black vs. white): RR = 2.5
- Smoking: RR = 2
- Oral contraceptive use: RR = 1.2 - 1.5
- Barrier Contraception: RR = 0.6

Note: A relative risk of 1.0 would indicate no increased probability of negative outcome, whereas RR of less than 1.0 means an actual protective effect may be present. RR of 10 means a tenfold increase. Overall risk for reproductive age nonhysterectomized American women to develop cervical cancer is about one in 5,200 per year, or 0.02%.

Patient Communication

Reminder postcards, letters, and telephone calls are integral components of a cervical cancer screening initiative:

- communication tools to inform women of Pap smear results
- explanations of next steps necessary to further diagnose abnormalities
- reminders regarding completing appropriate tests and/or examinations
- routine reminders for periodic Pap smears

Evidence supporting this recommendation is of classes: C, D, M, R

Definitions:

Conclusion Grades:

Grade I: The evidence consists of results from studies of strong design for answering the question addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of any significant doubts about generalizability, bias, and flaws in research design. Studies with negative results have sufficiently large samples to have adequate statistical power.

Grade II: The evidence consists of results from studies of strong design for answering the question addressed, but there is some uncertainty attached to the conclusion because of inconsistencies among the results from the studies or because of minor doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from weaker designs for the question addressed, but the results have been confirmed in separate studies and are consistent with minor exceptions at most.

Grade III: The evidence consists of results from studies of strong design for answering the question addressed, but there is substantial uncertainty attached to the conclusion because of inconsistencies among the results of different studies or

because of serious doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from a limited number of studies of weak design for answering the question addressed.

Grade Not Assignable: There is no evidence available that directly supports or refutes the conclusion.

Classes of Research Reports:

A. Primary Reports of New Data Collection:

Class A:

- Randomized, controlled trial

Class B:

- Cohort study

Class C:

- Nonrandomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

Class D:

- Cross-sectional study
- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports

Class M:

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R:

- Consensus statement
- Consensus report
- Narrative review

Class X:

- Medical opinion

CLINICAL ALGORITHM(S)

A detailed and annotated clinical algorithm is provided for [Cervical Cancer Screening](#)

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The guideline contains an annotated bibliography and discussion of the evidence supporting each recommendation. The type of supporting evidence is classified for selected recommendations (see "Major Recommendations").

In addition, key conclusions contained in the Work Group's algorithm are supported by a grading worksheet that summarizes the important studies pertaining to the conclusion. The type and quality of the evidence supporting these key recommendations is graded for each study.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Increased percentage of women who are up-to-date for cervical cancer screening
- Improved effectiveness of patient education by taking advantage of regular opportunities to inform women of the need for cervical Pap smear screening

Subgroups Most Likely to Benefit

Women at high risk of cervical cancer, especially women who are human immunodeficiency virus (HIV)-positive, women who have had moderate dysplasia on Papanicolaou (Pap) smear within the past five years, women who had intercourse within 1 year of menarche, and women with no prior screening (see "Major Recommendations" for additional risk factors).

POTENTIAL HARMS

Pap smears can result in false-positive and false-negative results.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.

- This clinical guideline should not be construed as medical advice or medical opinion related to any specific facts or circumstances. Patients are urged to consult a health care professional regarding their own situation and any specific medical questions they may have.
- There is not a consensus in the literature on whether there should be an upper age limit for cervical Papanicolaou (Pap) smear screening.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Once a guideline is approved for general implementation, a medical group can choose to concentrate on the implementation of that guideline. When four or more groups choose the same guideline to implement and they wish to collaborate with others, they may form an action group.

In the action group, each medical group sets specific goals they plan to achieve in improving patient care based on the particular guideline(s). Each medical group shares its experiences and supporting measurement results within the action group. This sharing facilitates a collaborative learning environment. Action group learnings are also documented and shared with interested medical groups within the collaborative.

Currently, action groups may focus on one guideline or a set of guidelines such as hypertension, lipid treatment, and tobacco cessation.

Detailed measurement strategies are presented in the original guideline document to help close the gap between clinical practice and the guideline recommendations. Summaries of the measures are provided in the National Quality Measures Clearinghouse (NQMC).

IMPLEMENTATION TOOLS

Clinical Algorithm
Quality Measures

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

RELATED NQMC MEASURES

- [Cervical cancer screening: percentage of women age 21 through 64 years continuously enrolled during the last twelve months having at least one cervical Pap smear during the past three years.](#)
- [Cervical cancer screening: percentage of women age 21 through 64 years seen at least once in the clinic during the past two years who are up-to-date for cervical cancer screening.](#)

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Cervical cancer screening. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Aug. 29 p. [56 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1994 Sep (revised 2004 Aug)

GUIDELINE DEVELOPER(S)

Institute for Clinical Systems Improvement - Private Nonprofit Organization

GUIDELINE DEVELOPER COMMENT

Organizations participating in the Institute for Clinical Systems Improvement (ICSI): Affiliated Community Medical Centers, Allina Medical Clinic, Altru Health System, Aspen Medical Group, Avera Health, CentraCare, Columbia Park Medical Group, Community-University Health Care Center, Dakota Clinic, ENT Specialty Care, Fairview Health Services, Family HealthServices Minnesota, Family Practice Medical Center, Gateway Family Health Clinic, Gillette Children's Specialty Healthcare, Grand Itasca Clinic and Hospital, HealthEast Care System, HealthPartners Central Minnesota Clinics, HealthPartners Medical Group and Clinics, Hutchinson Area Health Care, Hutchinson Medical Center, Lakeview Clinic, Mayo Clinic, Mercy Hospital and Health Care Center, MeritCare, Mille Lacs Health System, Minnesota Gastroenterology, Montevideo Clinic, North Clinic, North Memorial Care System, North Suburban Family Physicians, Northwest Family Physicians, Olmsted Medical Center, Park Nicollet Health Services, Pilot City Health Center, Quello Clinic, Ridgeview Medical Center, River Falls Medical Clinic, Saint Mary's/Duluth Clinic Health System, St. Paul Heart Clinic, Sioux Valley Hospitals and Health System, Southside Community Health Services, Stillwater Medical

Group, SuperiorHealth Medical Group, University of Minnesota Physicians, Winona Clinic, Ltd., Winona Health

ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; e-mail: icsi.info@icsi.org; Web site: www.icsi.org.

SOURCE(S) OF FUNDING

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GUIDELINE COMMITTEE

Preventive Services Steering Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: Jeanne M. Anderson, MD (Work Group Leader) (Family HealthServices Minnesota) (Family Practice); Brendon Cullinan, MD (Montevideo Clinic) (Family Practice); Caroline Mason, MD (HealthPartners Medical Group) (Family Practice); Janet Schmitt, MD (Fairview Health Services) (Family Practice); Dale Akkerman, MD (Park Nicollet Health Services) (Ob/Gyn); Brigitte Barrette, MD (Mayo Clinic) (Ob/Gyn); Carol Ball, MD (HealthPartners Medical Group) (Ob/Gyn); Adelaide J. Charlton, NP (Park Nicollet Health Services) (Nursing); Beth Green, MBA, RRT (Institute for Clinical Systems Improvement) (Measurement/Implementation Advisor); Nancy Greer, PhD (Institute for Clinical Systems Improvement) (Evidence Analyst); Jenelle Meyer, RN (Institute for Clinical Systems Improvement) (Facilitator)

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

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